Health First Network, Inc.
Moving Healthcare Forward

Chronic Care Management

Health First Network, Inc. is always looking for ways to help our physicians take maximum advantage of new programs. As of January 01, 2015, the Center for Medicare and Medicaid Services (CMS) approved a Chronic Care Management code (CPT 99490) that allows eligible providers to bill for non-face-to-face time invested by members of the clinical care team. HFNI is piloting a program to assist our physician practices to provide, document, and bill for this new service, which has the potential to appropriately reimburse for a critical need that all of our Physicians, but especially our Primary Care Physicians, have provided without specific compensation.

The code may be billed once every calendar month during which a minimum of 20 minutes of non-face-to-face chronic care management time is documented in a certified Electronic Medical Record (EMR) for each patient…but it's not as easy as it sounds. Because of the potential stumbling blocks, few providers are billing for this service as yet, and those who are frequently run into problems. Here are the "bare bones":

CMS has identified a list of 27 diseases they recognize as chronic, and another 14 or so that "may" be considered chronic; any patient with two or more of these conditions (which are expected to last at least a year and up to a lifetime) would qualify for the CCM service.

An eligible provider, for billing purposes, must be a physician, ARNP/APRN, PA, or nurse midwife; for purposes of actually providing the elements of the service, licensed and/or certified clinical staff under appropriate medical supervision are included as well (both billing and providing personnel constitute the "care team" for any particular patient).

CMS has identified three "core requirements" that must be satisfied:

1. The provider's office must obtain, and maintain as part of the EMR, the patient's (or legal representative's) written consent. It needs to be obtained once; however, they may rescind the permission at any time, at their discretion;
2. The provider's office must have five specified capabilities:
    a. Use of a certified EMR for specified purposes;
    b. Maintain an electronic care plan;
    c. Ensure access to care;
    d. Facilitate transitions of care;
    e. Coordinate care.

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3. The provider's office must provide and document a minimum of 20 minutes of non-face-to-face care management services.

There are some caveats that are important, and will add to the potential confusion. For example, only one physician may bill this service in a calendar month, and the service cannot be billed in the same month as Transition of Care Management (CPT 99495 or 99496), Home Healthcare Supervision (HCPCS G0181), Hospice Care Supervision (HCPCS 0182), or certain ESRD services (CPT 90951-90970). Another potential problem for some patients and their care givers is the fact that this service is subject to beneficiary deductibles and coinsurance.

Current reimbursement for properly provided, documented, and billed CCM is $42.70 per qualified patient, per calendar month in our area (it varies geographically).

We will be reaching out to our PCP offices with details of what we can do to help, but anyone who has interest or questions, please call me at 850-434-8147 or email me at **WWhibbsMD@hfni.com.**

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